STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
DIVISION OF REHABILITATION SERVICES

APPEAL FOR FAIR HEARING BY REHABILITATION SERVICES

Date Appeal Requested _____
Date Received _____
County or Facility _____

SECTION 1
(To be completed by the appellant or his/her representative)

I hereby appeal for a fair hearing regarding the case of:

_____ _____
Name of Appellant Street Address

_____
City State Zip Code

My grievances are as follows: _____

_____

_____

_____

SIGNED: _____

Oral Request: _____
Date

_____
Street Address

_____
City State Zip Code

Telephone Number: ( ) _____

SECTION II
(To be completed by the local office)

Case Name _____ SSN _____

The reason for the appeal: (check one)
☐ Determined Ineligible ☐ Civil Rights Violation ☐ Other (explain) _____
☐ Termination of Services ☐ Reduction of Services _____

_____

Mailing Date of Notice _____ Effective Date _____

Reason for the action or delay in action: Explain briefly, indicating whether the issue is a protest of agency policy or a matter of fact or judgment relating to the individual case. Attach copies of the notice that was mailed to the appellant.

_____

_____

_____

_____

Services Continued: [ ] Yes
[ ] No

_____Counselor

_____
Regional Supervisor or Facility Administrator